Sutter Roseville Medical Center
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To Whom It May Concern:

My name is Sophie Harnage , and I am the Clinical Manager of Infusion Services and the Vascular Access Team at Sutter Roseville Medical Center, in Roseville California. My facility has currently gone four years without a single infection from our PICC lines as a direct result of a customized bundle approach that our team has taken to reduce catheter-related bloodstream infections. By adhering consistently to this custom bundle and using the best technologies available, we have been able to afford our patients the most comprehensive program for prevention of Catheter-Related Bloodstream Infections. In response to your request for public comment for the currently proposed Draft Guidelines for the Prevention of Intravascular Catheter Related Infections, I would like to offer my support of a change in the verbiage of the recommendation specifically for skin antisepsis. My facility is currently in the process of switching from the 2% alcoholic CHG Solution (Chloraprep®) to the 3.15% alcoholic CHG solution (Chlorascrub™) because of improved efficacy, ease of use for the clinical staff, and tremendous cost savings. The 3.15% alcoholic CHG solution contains the same FDA approvals as a skin antiseptic as the 2% alcoholic CHG solution, which was the only solution available at the time of the last publication of this guideline in 2002.

Currently the draft guideline calls for a 2% Chlorhexidine based skin antiseptic solution to be used for central venous catheter insertion. The current Infusion Nurse's Society Standards for Care (INS), the Society for Healthcare Epidemiology of America (SHEA), and the Infectious Diseases Society of America (IDSA) all have released recent guidelines that support the use of an alcoholic chlorhexidine solution containing a concentration of chlorhexidine gluconate (CHG) greater than 0.5% CHG. The current draft CDC document does not call for an alcoholic CHG solution, and only makes reference to a 2% CHG solution. The specific study referenced used an aqueous solution of CHG. The synergistic effects of CHG and isopropyl alcohol are key to providing initial skin antisepsis and also persistent activity of CHG on the patient's skin. Use of an aqueous based CHG solution alone would not provide adequate initial skin antisepsis. I would urge the HICPAC committee to make a more inclusive recommendation that is in line with the current standards of other Infection Prevention organizations and change the guidelines verbiage to read "use an alcoholic Chlorhexidine gluconate solution greater than 0.5% CHG." This would minimize confusion amongst clinicians, and offer all patients the benefits of Chlorhexidine gluconate. I would highly suggest making the following modifications to the draft guideline as follows:

Line 58, Page 2-Change "using a 2% Chlorhexidine preparation for skin antisepsis" to **"use a greater than 0.5% alcoholic Chlorhexidine preparation for skin antisepsis."**

Line 63, Page 3-Change "and 2% Chlorhexidine preparation for skin antisepsis" to **"use a greater than 0.5% alcoholic Chlorhexidine preparation for skin antisepsis."**

Line 426, Page 19-Change "prepare clean skin site with a 2% Chlorhexidine-based preparation before central venous catheter insertion and during dressing change" to **"use a greater than**

0.5% alcoholic Chlorhexidine preparation for skin antisepsis for all vascular access."
Advocating a 70% alcohol solution for peripheral venous catheter insertion, but not for central venous catheter insertion creates two different standards of care for vascular access. We at Sutter Roseville offer all of our patients with vascular access the benefits of CHG, not just those receiving central venous therapy.

Line 1436, Page 66-Change "prepare clean skin site with a 2% Chlorhexidine-based preparation before central venous catheter insertion and during dressing change" to **"use a greater than 0.5% alcoholic Chlorhexidine preparation for skin antisepsis for all vascular access."**

Additionally, the recommendation for use of CHG for insertion of peripheral intravenous catheters has been changed to isopropyl alcohol, which creates two standards of care for our patients. We would like one standard for care for our patients for all vascular access procedures. I would strongly urge the HICPAC committee to evaluate this request to be inclusive of all CHG containing skin antiseptics available under the formal approval of the Food and Drug Administration.

In regards to the guideline's recommendations surrounding site maintenance, the current recommendation is to use either sterile gauze or a sterile, transparent, semi-permeable dressing to cover the catheter site. The study referenced was published by Maki et al in 1987 and is seriously outdated. We have completely eliminated gauze dressings from our facility due to higher risk for colonization of these types of dressings.

Finally, I would also appreciate the recommendation regarding the cleaning of ports and hubs with either alcoholic Chlorhexidine (CHG preferred) or 70% isopropyl alcohol to be consistent with that of other organizations such as SHEA. Therefore, my recommendation would be to word this particular piece as "before accessing catheter hubs or injection ports, clean them with an alcoholic Chlorhexidine preparation (preferred) or 70% alcohol to reduce contamination." This will give clarity to clinicians about the appropriate cleaning of these devices that serve as sources for contamination.

Thank you for your consideration. If you have any questions, please feel free to contact me directly using the contact information below:

Best regards,

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